Letters

All letters are subject to editing and may be shortened. Letters should be sent to the BJGP office by e-mail in the first instance, addressed to **journal@rcgp.org.uk** (please include your postal address). Alternatively, they may be sent by post (please use double spacing and, if possible, include a MS Word or plain text version on an IBM PC-formatted disk). We regret that we cannot notify authors regarding publication.

An unfortunate man

With reference to Dr Baker's Mackenzie lecture,[1] I sometimes think that we are in danger of forgetting that John Berger, the author of *A Fortunate Man* is, among his many other intellectual pursuits, a novelist.[2]

His description of the work of Dr John Sassall was an interpretation of someone else's life experience in the distinctive style of the author. Berger has remarked himself that:

> '*Some say of my writing that it is too overburdened with metaphor and simile: that nothing is ever what it is but is always like something else*'.[3]

The images and feelings portrayed by Berger are stories conveying his particular vision of being a country doctor. As doctors, we feel a resonance with the humanity displayed in the book, but are perhaps seduced into wishing to emulate the lifestyle by the beautiful obliquity of the language and a yearning for an ideal doctor–patient relationship involving mutual respect, empathy and development.

As well as being longitudinal (a rare luxury these days), Dr Sassall's relationship with his patients was interwoven (even rarer). It is, and was, a hard act to sustain and is perhaps reflected in the tragic irony of the book's title in view of Dr Sassall's suicide several years after publication.

Colin R Cuthbert
General Practitioner
Barnard Castle Surgery, Barnard Castle, County Durham, DL12 8HT.
E-mail: Colin.Cuthbert@gp-a83046.nhs.uk

REFERENCE

1. Baker R. The clinical observer — on the up or over the hill? *Br J Gen Pract* 2005; **55:** 468–471.
2. Berger J. *A fortunate man: the story of a country doctor.* London: RCGP, 2005.
3. Berger J. *G.* New York: Panthenon, 1980.

Domestic violence in the Bengali community

We report the results of a study to investigate the context of domestic violence towards women in the Bengali Community of East London through the perspectives of healthcare workers.

Domestic violence is a universal phenomenon affecting all cultures.[1] A key to its understanding is the cultural context within which it is manifested; research in this area is sparse although it has been explored in Bangladesh.[2] It is common, with 41% of women attending general practice having 'ever experienced physical violence'. While screening may not be justified,[3] women expect healthcare workers to ask about and support them.[4]

This was a qualitative study using semi-structured interviews, approved by ELCHA ethics committee. The setting was The Bromley by Bow Centre in East London. There were 11 subjects including healthcare workers, GPs and health visitors. The results revealed themes including:

CAUSE OF ABUSE

Acculturation and cross-community marriages in Bangladesh and the UK could create tension that could precipitate violence, as could in-laws cohabiting with couples.

TYPES OF ABUSE

These were thought to include exploitation of lack of education of immigrant women and girls, physical beatings, financial deprivation and social isolation. The community's slander of a 'bad wife' could be used as psychological abuse.

SECRECY

Perpetrator families were thought to keep abuse hidden as did the victim. In seeking help, the victim was thought to be fearful of retaliation and inhibited by the constant presence of her in-laws.

> '*… she told the GP that she fell from the chair … it was too difficult for her to* [tell] *because one of her family was interpreting for her …*'

LACK OF SUPPORT

Wives who leave their own support structure behind can become isolated and their new family may not support her. The community was thought to be unsupported in dealing with domestic violence and the police and social services were thought unhelpful.

ENDING THE ABUSE

The consensus was that professionals thought that women wanted to remain in the family (where this was safe) and enabling this was the ideal.

The conclusions are that this study found that domestic violence within this community, although reflected in other cultures, was also affected by the interface of their own host and native culture. The context can create a culture of secrecy and lack of support, which does not help the victims of domestic violence. The views are 'secondhand' via the health professional and may reflect their preconceptions, but they give an insight, perhaps, into some of the issues surrounding this sensitive subject.

Charlotte O'Doherty
Senior House Officer in Accident and Emergency, Lister Hospital, Stevenage,

Hertfordshire SG1 4AB.
E-mail: codoherty@doctors.org.uk

Melvyn Jones
Senior Lecturer, Royal Free & UC Medical School, London.

REFERENCES

1. Jewkes R. Intimate partner violence: causes and prevention. *Lancet* 2002; **359:** 1423–1429.
2. Schuler SR, Hashemi SM, Riley AP, Akhter S. Credit programs, patriarchy and men's violence against women in rural Bangladesh. *Soc Sci Med* 1996; **43(12):** 1729–1742.
3. Ramsay J, Richardson J, Carter YH, Davidson LL, Feder G. Should health professionals screen women for domestic violence? Systematic review. *BMJ* 2002; **325(7359):** 314.
4. Richardson J, Coid J, Petruckevitch A, *et al.* Identifying domestic violence: cross sectional study in primary care. *BMJ* 2002; **324(7332):** 274.

Workplace assessment

Further to the paper 'Workplace assessment for licensing in general practice'[1] we write to update you of current developments in the development of a workplace assessment for the new licensing examination.

The RCGP and the Committee of General Practice Education Directors are working collaboratively through a workplace assessment steering group on a number of pilot projects in 2005–2006 in preparation for a new assessment package to go live in 2007. It is proposed that the new workplace assessment will comprise a trainer's report triangulated with some externally assessed work-based tests. A new competency-based trainer's report is in design based around a set of holistically determined competencies derived from the emergent RCGP Curriculum. Evidence for this report will be garnered from the workplace as outlined in the above 'principles' paper. In addition, a number of reliability and validity studies are being performed to develop tools for the external triangulation of workplace findings.

Workplace assessment is only one of three assessments in development, the other two being a Clinical Skills Assessment module and an applied knowledge test. The RCGP, assisted by a designated Assessment Fellow, is ensuring that all three of the proposed modules for the new examination interrelate appropriately and draw down directly fro the new Curriculum. All those involved are committed to developing a new assessment programmes that is robust and fit for purpose while remaining mindful of the assessment burden on future generations of trainees.

RCGP Workplace Assessment Steering Group
Elisabeth Paice
Shelly Heard
Neil Jackson
McKenzie House, 20 Guildford Street, London, WC1N 1DZ.

REFERENCE

1. Swanick T, Chana N. Workplace assessment for licensing in general practice. *Br J Gen Pract* 2005; **55:** 461–467.

The merits of homeopathy

Dougal Jeffries has actually done a better job than I could have done in introducing the merits of homeopathy![1] He rightly admits that it often makes people better, is harmless and is cheap. I, like many GPs across the country, often feel quite uncomfortable when trying to persuade a healthy 50-year-old asymptomatic, hypertensive patient to take a second or possibly a third drug for the rest of their life that isn't actually curing anything; quite possibly has unpleasant side effects; needs monitoring for potential harm; and costs the country a fortune.

Naturally there is a place for homeopathic treatment, and obviously many instances where its use is totally inappropriate. However, when practised by properly trained medical practitioners, who can offer 'the best of both worlds', it should rightly deserve its place as a useful and respected complementary, not alternative, therapy. We, as doctors, should all be more open minded about less mainstream therapies and not so shackled by the issues of scientific proof and evidence-based medicine. Much of the value and quality of good general practice comes from recognising the individual patient's experience of his or her illness and response to treatment.

If Jeffries' friends and relatives tell him of good results from homeopathic treatments, does he think that they are deluded or deceived by their healer? Or bowled over into submission by the much maligned placebo effect? Perhaps he feels a little threatened that patients have a need to seek help where conventional science has failed them? Or maybe a little envious that some of his colleagues have learnt some extra skills that we can put to use? Maybe he should enrol on a preliminary course and find out more about it for himself.

So how does homeopathy work? I don't know and I really don't care much. There are plenty of other worldly issues that defy understanding by the scientific methods of today, so I tend not to get too hung up about it. The memory of water is only one theory anyway. The real issue is that it does work, often dramatically, producing outstanding results in conditions that can be very tricky to treat conventionally, for example, morning sickness, behavioural and emotional disorders, irritable bowel and a host of what may be called 'psychosomatic disorders' that most specialists wouldn't or can't touch with the proverbial barge pole. And the old chestnut of the placebo affect and the 'long consultation'? Babies and animals are not in the habit of falling for the 'nice doctor' charms but still do remarkably well.

So where is the deception? Usually, patients that receive homeopathic treatment, often from trained GPs working on 10-minute consultations, are as openminded as their practitioner and actually value the end result, irrespective of whether their little white tablets have actually been blessed with the contact of a molecule of the remedy. More importantly, how many of us would actually discuss the numbers-needed-to-treat statistics with that hypertensive patient and feel we are improving the quality of his life?

Andrew Hillam
NHS Primary Care representative for the Faculty of Homeopaths
E-mail: andrewhillam@ukonline.co.uk

REFERENCE

1. Jeffries D. Homeopathy — a benign deception? *Br J Gen Pract* 2005; **55:** 490.